MONTANA STATE HOSPITAL
FORENSIC MENTAL HEALTH FACILITY
POLICY AND PROCEDURE

TREATMENT PLANS FOR PATIENTS AT THE FORENSIC MENTAL HEALTH FACILITY

Effective Date: February 1, 2016 **Policy #:** MSH FMHF-13

I. PURPOSE: To establish policies and procedures for the initiation, development, implementation, and review of treatment plans for each patient at the Montana State Hospital (MSH) Forensic Mental Health Facility (FMHF). Treatment plans are necessary to guide the multidisciplinary treatment team as they attempt to assist the patient in their recovery and return to a less restrictive treatment environment.

II. POLICY: It is the policy of the MSH FMHF to initiate, develop, implement, and review treatment plans in accordance with state statutes and administrative rules.

A. Patients have the right to ongoing participation in their treatment plan.

B. Patients have the right to a reasonable explanation of their treatment plan.

C. The treatment plan reflects a multidisciplinary, comprehensive, holistic, culturally sensitive approach to evaluating and treating each patient.

D. Overall development, implementation, and supervision of the treatment plan is the responsibility of the patient's attending Licensed Independent Practitioner (LIP). Responsibility for ensuring that the treatment plan is accurate, up-to-date, and reviewed regularly may be delegated to a certified mental health professional.

E. The treatment plan is individualized to the needs of the patient.

F. The treatment plan describes the least restrictive conditions and interventions necessary to meet the individual patient's needs.

G. The treatment plan attempts to clarify the patient's responsibilities, including a list of potentially therapeutic activities.

H. The treatment plan includes:
   1. A precise description of the patient's specific strengths.
   2. A precise description of the patient's psychiatric disabilities and disorder.
   3. A precise description of the patient's physical and medical disabilities and disorder.

4. A precise description of the patient's problem behaviors associated with their psychiatric or physical disabilities, which are prioritized.
5. A precise description of the patient's diagnosis.
6. Long-range goals that are:
    a. Individualized to the patient's needs.
    b. Appropriate for the identified problems.
    c. Described as specific behavioral outcomes for the patient (observable and measurable).
    d. Dated (expected date of achievement).
7. Short-term goals that are:
    a. Individualized to the patient's needs.
    b. Appropriate for the identified problems.
    c. Described as specific behavioral outcomes for the patient (observable, measurable).
    d. Dated (expected date of achievement).
8. Treatment modalities/interventions for each goal that are:
    a. Individualized to the patient's needs.
    b. Focused on the identified problems.
    c. A realistic and appropriate means for achieving the identified goals.
    d. Stated as specific interventions rather than general services.
9. A list of the individuals responsible for the interventions, including the individual's discipline/profession.

I. The treatment plan reflects an active approach to identifying and treating the needs of the patient.

J. The treatment plan is reviewed regularly and revised in a manner designed to promote more effective treatment and less restrictive treatment conditions.

K. Treatment plans will be provided to the patient or the guardian.

L. Training will be provided to educate staff on procedures for the development, implementation, and review of treatment plans.

III. DEFINITIONS:

A. Treatment Plan: An electronic or paper document that describes the patient's individualized diagnosis, strengths, disabilities, problem behaviors, needs, long-range goals, short-term goals, treatment interventions, and treatment providers.

B. Integrated Summary: An electronic or paper document that consolidates and summarizes the available information about a patient, from a variety of sources (patient's perceptions, family perceptions, collateral information, available history, current assessments). The document is used to help develop the treatment plan.

C. Licensed Independent Practitioner (LIP): Attending physician (usually a psychiatrist) or advanced practice registered nurse with a clinical specialty in psychiatric mental health.

D. Treatment Team: The Treatment Team consists of the patient, the LIP, and other identified staff and professionals. Family/friends/advocates/guardians also should be involved in treatment planning process whenever possible.

E. Certified Mental Health Professional (CMHP): A person who has been certified by the Department of Public Health and Human Service according to MCA 53-21-106.

IV. RESPONSIBILITIES:

A. MSH FMHF Program Manager: Monitors treatment planning at the FMHF to ensure that treatment plans are completed in a timely manner, meet the established standards, and are reviewed at appropriate intervals.

B. Supervisors: Responsible for communicating and training staff on the content of this policy.

C. Staff Development: Responsible for orienting all new employees on this policy.

V. PROCEDURES:

A. Initiation of treatment plan:
   1. The multidisciplinary treatment team, directed by the LIP, will initiate treatment deemed necessary for the patient as soon as possible after admission even though the treatment plan may be in development.
   2. The LIP will provide the patient with an explanation of the risks and benefits of recommended treatment.
   3. The LIP will obtain the patient's consent for treatment. If the patient has a legal guardian, the provider will obtain their consent for treatment.

B. Development of treatment plan:
   1. The patient will receive a nursing assessment within 48 hours of admission and the results will be incorporated into the treatment plan.
   2. The patient will receive a physical examination within forty-eight (48) hours of admission and the results will be incorporated into the treatment plan.
   3. The patient will receive a psychiatric examination within seven (7) days of admission and the results will be incorporated into the treatment plan.
   4. The patient will receive a social assessment within fourteen (14) days of admission and the results will be incorporated into the treatment plan.
   5. The patient will be offered the opportunity to express (oral or written) their perception of their treatment needs and preferences. Advance directives, when available, will be incorporated into the treatment plan.

6. The patient's family, guardian, or significant others will be offered the opportunity to provide their perception of the patient's treatment needs.
7. The multidisciplinary treatment team will provide supplemental assessments of the patient and the results will be incorporated into the treatment plan.
8. Available information from collateral sources (other hospitals, current care providers, court officials, etc.) will be incorporated into the treatment plan.

C. Integrated summary:
   1. Prior to the formalization of the treatment plan, the treatment team will meet to integrate the available information about the patient's treatment needs. The team will identify, clarify, and prioritize the patient's disabilities and needs to be included on the treatment plan. The team will identify, clarify, and formalize the treatment goals and recommended treatments.
   2. The results of the treatment team's review and plan will be described on the Integrated Summary document (hard copy or electronic).
   3. The Integrated Summary document will be completed within seven (7) days of the patient's admission. The Summary will be signed and dated by members of the multidisciplinary treatment team.
   4. The Integrated Summary will be used to guide the development of the treatment plan.

D. Treatment plan:
   1. A formal individualized treatment plan will be completed by a certified mental health professional within ten (10) days of the patient's admission.
   2. The treatment plan will be documented (electronic or hard copy), dated, and signed by treatment team members.
   3. The multidisciplinary treatment team will present the treatment plan to the patient or guardian, offer explanation, answer questions, and provide a copy. The patient or guardian will have an opportunity to express her/his opinions about the information on the treatment plan and sign the plan.

E. Treatment plan reviews:
   1. Treatment plans are reviewed:
      a. At least every 90 days;
      b. Whenever there is a significant change in the patient's condition (including changes resulting in the need for more restrictive interventions such as seclusion or restraint);
      c. At the time of any transfer within the MSH;
      d. At the time of a transfer to a group home on the hospital campus;
      e. At the time of discharge.
   2. Each treatment plan review should include as many treatment team members as possible but must involve at least two Certified Mental Health Professionals (LIP and CMHP), and include a staff who is not primarily responsible for implementation of the plan.

3. The results of the review must be documented with the changes entered on the treatment plan as indicated. Each treatment plan review must be dated and indicate who was involved in the review, and filed in the treatment plan section of the chart.

F. Upon admission each patient will have a nursing assessment completed by a registered nurse within forty-eight (48) hours which will include a preliminary treatment plan. Upon further assessment of the patient, a comprehensive treatment plan will be developed by the LIP, the patient and other multi-disciplinary team members. The preliminary treatment plan may be modified, but will be used as a guide for treatment and modalities to be used until a comprehensive treatment plan is developed within ten (10) days after the person's admission.

G. Consultation and outside treatment services:
   1. Treatment services provided by outside providers on a regularly scheduled basis (e.g., physical therapy, speech therapy) will be identified on the treatment plan. Refer to Consultation policy TX-05.

H. Staff members will use a treatment plan and treatment plan review format that has been approved for use by the Hospital Administration.

VI. REFERENCES: Montana Statute (53-21-162, M.C.A.); Administrative Rules of Montana 37.106.1916; Consultation Policy TX-05; Documentation in Progress Notes HI-05.

VII. COLLABORATED WITH: Director of Rehabilitation Services, Program Managers; Director of Quality Improvement; Director of Health Information Resources; Director of Nursing; Medical Director; Hospital Administrator; Clinical Services Director.

VIII. RESCISSIONS: None, new MSH FMHF policy.

IX. DISTRIBUTION: All MSH FMHF policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Clinical Services Director

XII. ATTACHMENTS: None.

_____/___/__		_____/___/__	
John W. Glueckert	Date	Thomas Gray, MD	Date
Hospital Superintendent		Medical Director	